



CASE REPORT

Coronary Artery Bypass Graft Surgery in a Young Female with Systemic Lupus Erythematosus and its Operative Challenges: A Case Report

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Summary

We understand that an autoimmune disorder such as Systemic Lupus Erythematosus increases the likelihood of developing coronary heart disease. However its implications on patients undergoing cardiac surgery are not well understood. Here we present a female patient with SLE who developed coronary artery disease at a young age and underwent coronary artery bypass graft surgery. As SLE is associated with vasculitis, we wanted to understand regarding the choice of conduit as well as its long term patency and also whether percutaneous angioplasty has a role to play in patients with SLE.

Keywords

SLE, Coronary artery disease, Cardiac surgery

ciated with high morbidity and mortality. Although the usual conditions in SLE such as vasculitis and nephritis are commonly focused on, its association with coronary artery disease should not be ignored. The overall prevalence of coronary heart disease in SLE ranged from 6-10% [2]. A study done by Manzi, et al. showed that women with SLE in the age group of 35-44 were 50 times more likely of developing coronary artery diseases compared to women with similar age group in the Framingham Study [2]. As of now, not many reports are available in regards to Coronary artery bypass graft surgery in SLE patients. In this case report, we write our experience on performing a CABG on a SLE patient.

Case Report

Introduction

Systemic Lupus Erythematosus is an autoimmune disorder that tends to affect multiple organs. Patients with SLE have a high risk of cardiovascular events due to atherosclerosis [1]. Most of patients with SLE, particularly at a young age do not have the classical risk factors that contribute towards the development of cardiovascular disorders [1]. Evidence in recent studies have shown that the development of atherosclerosis in SLE patients are strongly associated with inflammation and active immunological response which is a total contrast to the usual belief that atherosclerosis is formed from the accumulation of lipids in the walls of arteries [1]. Premature atherosclerosis formation leading to coronary artery disease is of major concern as it is asso-

Miss S, a 31-year-old female, was electively admitted to the Cardiothoracic Surgery ward, Hospital Sultanah Aminah, Johor Bahru for coronary artery bypass graft surgery. She was diagnosed with Systemic Lupus Erythematosus in 2007 complicated with lupus nephritis when she presented with a week history of malar rash and currently under rheumatology follow up. Her past medical history includes hypertension and dyslipidemia for the past 10-years. In 2016, she developed an acute onset of chest pain which was crushing in nature radiating to the left arm. Electrocardiogram done in the Emergency Department showed inferior myocardial infarction which was successfully thrombolysed with streptokinase. Coronary angiogram done in 2017 shows distal Left main stem occlusion of 80% with a proximal

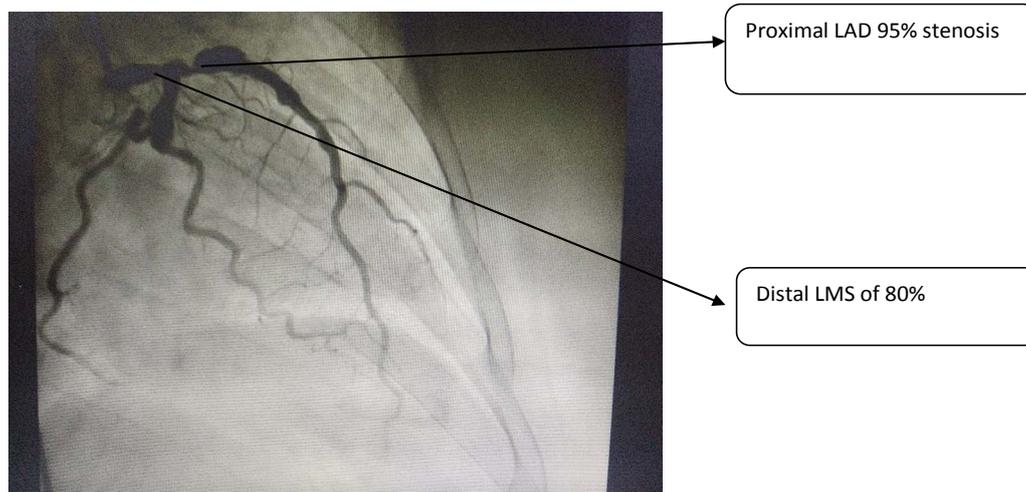


Figure 1: Distal Left main stem lesion with discrete proximal left anterior descending stenosis.

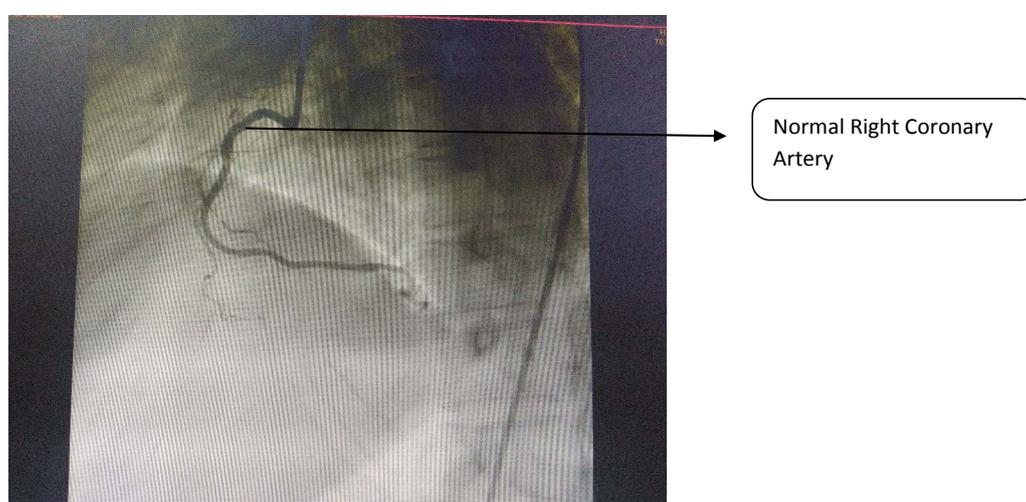


Figure 2: Normal Right coronary artery.

Left anterior descending lesion of 95%. Other areas of the coronary vessels were fairly normal (Figure 1 and Figure 2). She successfully underwent coronary artery bypass graft surgery on March 2019. The Left Internal Mammary artery was anastomosed to the left anterior descending artery and saphenous vein graft anastomosed to first obtuse marginal. Pre-operatively, her renal functions were normal. Her post-operative recovery was uneventful and her systemic steroids were continued. Renal function repeated during her post-operative period showed no derangement. Sternotomy and saphenous vein harvest site wound appears clean. She was discharged well on the seventh post-operative day.

Discussion

Planning for a coronary artery bypass graft surgery in this patient poses a lot of challenges. Due to the fact that SLE is a progressive disease, we were concerned about the patency of the grafts and the possibility of a redo surgery later on. The continuous inflammatory process as discussed above could possibly cause atherosclerosis in the right coronary artery and possibly

requiring redo CABG later on.

The type of conduit to use was also important to consider. The most important question is whether CABG surgery performed in a patient with compromised life expectancy due to multisystem involvement and high possibility of postoperative wound infection due to steroid use. The reported postoperative complications in these group of patients were 44% which included early graft thrombosis, bleeding and ventricular tachycardia [3]. Rinaldi, et al. studied 2 patients with underlying SLE that underwent CABG, both treated with a left internal mammary graft. Biopsy from both the grafts showed non-involvement by SLE although SLE is associated with arteritis [4]. Despite this, there is still no guarantee that the grafts would not develop intimal hyperplasia in the future [4]. Ura, et al. found that the early graft patency rates were 83.7% but however due to coexisting medical conditions such as diabetes mellitus, hyperlipidemia and lupus nephropathy in SLE patients, saphenous vein graft appear to deteriorate early [3].

Bruce W Lythle, et al. in the study the effect of

bilateral internal thoracic artery grafting on survival during 20 post-operative years found bilateral internal thoracic artery grafting produces improved survival compared with single internal thoracic artery grafting, however Nicholas T Kouchoukos, et al. in the study risks of bilateral of internal mammary artery bypass grafting found bilateral IMA grafts to be associated with higher incidence of sternal infections and should be used selectively in obese or diabetic patients [5,6]. In our patient, she is on long term corticosteroids due to her underlying SLE, which therefore poses higher risk of sternal wound infection in the long term. In this case, single IMA and vein graft is used instead.

There is one case reported whereby a SLE patient who underwent a bypass surgery was then followed by Percutaneous Transluminal Coronary Angioplasty (PTCA) [4]. The successful PTCA avoided reoperation for this patient but nevertheless, the overall outcome of coronary arteries treated with PTCA is still not known. Wilson, et al. reported 2 cases of patients with SLE and acute myocardial infarction who were treated with PTCA [7]. Both of them sustained reocclusion of the dilated vessel and 1 died. Therefore, whether PTCA can be used as primary therapy or secondary to failure of coronary artery bypass grafting remains to be seen as experience needs to be accumulated.

Conclusion

Due to enhanced medical management offered to patients with SLE to increase life expectancy, the large dose of corticosteroids raises the possibility of coronary involvement. The inflammatory manifestation of the disease itself further increases the possibility of developing coronary artery disease. Although not much information is available regarding the choice of conduit and its implications, the usage of internal mammary artery and saphenous vein graft can still benefit patients with SLE as graft patency rates were reported as 83.7% [3]. However we feel that more long term follow up is required to comment on graft patency. Angioplasty was not done for our patient as the lesion was at the left main stem. Whether or not PTCA would benefit patients who are suitable for angioplasty in the long run still needs more research. On the whole we believe that CABG in a SLE patient can be performed with acceptable

morbidity and mortality in spite of coexisting complex diseases [3].

In this case repost, the management strategy would remain the same which is CABG. However, we wanted to understand the patency of conduits. As SLE itself is an autoimmune disease and poses high possibility of vasculitis. In view of CABG is done at a very young age, we were curious on the possibility of a redo surgery later on due to the progression of the disease on the grafts, Ura, et al. demonstrated a good and acceptable patency rates. Hisashi, et al. documented on a case report of on successful bilateral internal mammary artery grafting to a patient with SLE [8]. Probably in the future, we would consider this for our patients here.

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